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ABSTRACT

Two papers are presented and discussed in this report. The first is "Integration of Health Education Services with Other Services for Children and Young People," and the second is "Health Education of Educators." Discussion of these two papers centered around three topics: identification of the health education component of all relevant services and professions; identification of factors promoting and/or hindering the integration of health education in these services and professions; and the investigation of the process whereby integration of the relevant services and professions may be initiated and completed. A list of participants is included. (DS)

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ВСЕМИРНАЯ ОРГАНИЗАЦИЯ ЗДРАВООХРАНЕНИЯ
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HEALTH EDUCATION OF CHILDREN AND YOUNG PEOPLE

Report on a Working Group

Dublin
23-26 May 1978

U.S. DEPARTMENT OF HEALTH, EDUCATION & WELFARE
NATIONAL INSTITUTE OF EDUCATION

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1. Introduction

The Working Group on Health Education of Children and Young People was convened by the WHO Regional Office for Europe, in cooperation with the Government of Ireland, at Dun Laoghaire near Dublin from 23 to 26 May 1978. Its purpose was to examine means whereby (1) effective integration of the various services concerned with children and young people may be achieved for the purposes of health education; and (2) health educators may themselves be educated.

The Group was attended by 17 temporary advisers from 12 countries of the WHO European Region as well as 4 staff members of the Regional Office (see Annex).

Participants were welcomed to Ireland and to Dun Laoghaire by Dr B. Hensey who represented the Minister of Health. Then, speaking on behalf of Dr Leo A. Kaprio, WHO Regional Director for Europe, Dr D.K. Sokolov, Director, Development of Comprehensive Health Services, said that the Regional Director attached much importance to health education, both professionally and personally, and was particularly interested in the outcome of the meeting. It was hoped that the Group's conclusions and recommendations would further strengthen the Regional Office's work in health education.

After the meeting had been opened by Dr A.P. Woudenberg, Regional Officer for Health Education and Social Sciences, it was agreed that Mr B.R. Carr would act as Chairman of the Group and Mr I. Sutherland as Rapporteur.

2. Background

In 1974 the World Health Assembly adopted resolution WHA27.28 on the health education of children and young people. In its preamble, the resolution states that WHO should pay special attention to the harmonious development and training of the rising generations with a view to the building of a healthy society. It also mentions the important role of health education in protecting children and young people against undesirable features of our era, such as the tobacco habit, alcoholism and drugs. Hence it calls for intensified action within WHO's programmes to ensure that children and young people receive a multidisciplinary health education, and the promotion of new approaches for solving the problems faced. The Group was convened to discuss matters relating to the attainment of this objective.

In particular, it was felt that in achieving multidisciplinary health education for children and young people, consideration should be given to using agencies and services not directly concerned with health care. Collaboration of this kind involves not only an appropriate organizational structure for health, education and other social services, but also the participation of individuals as well as professional and lay groups. Parents in the first place but also teachers, social workers, police, clergy, youth club workers, athletic trainers, health personnel and other adults give guidance to children and young people and require an understanding of the principles and methods of health education. Thus the Group was asked to discuss the organizational and educational measures needed in integrating activities for this purpose.

In its discussions the Group took into account the reports of earlier WHO meetings on: the evaluation of maternal and child health services in certain countries of the European Region (Copenhagen, 1973 (EURO 5103(2)); problems of children of school age 5-9 years (Copenhagen, 1975 (ICP/MCH 004)), 10-13 years (Moscow, 1976 (IGP/MCH 006)) and 14-18 years (Amsterdam, 1977 (ICP/MCH 010)); the place of health education in health administration (Manchester, 1976 (ICP/HED 003)); and principles and methods of health education (Dresden, 1977 (ICP/HED 004)). A study of health education in mental health programmes (ICP/MNH 033 III) was also reviewed.

Two working papers were prepared and presented to the Group:

- "The integration of health education services with other services for children and young people" by Dr E. Dekker; and

- "The health education of the educators" by Dr Eva-Mari Köhler.

3. Integration of health education services with other services for children and young people

3.1 Presentation

Because health problems are now for the most part chronic and associated with the behaviour of people, because costs are rising and because the population wishes to be more closely associated with the services provided, there is a growing interest in health education. There is also

growing expectation of the benefits it might provide. Action in response to this interest and expectation should not only consist of producing more and better health education materials but also, more radically:

(1) integrating policy and administration,

(2) improving knowledge and information, and

(3) harnessing the desire of people to participate in decisions.

Health education is indeed the responsibility of the whole community.[a]

Among children and young people, health ecucation is concerned with primary socialization; adaptation in respect of adults and approaching adulthood; consumer practice both in commercial terms and in the use of services. Thus any system dealing with health among children and young people should not consider them in isolation; they experience both specific influences and influences of a general nature, and consequently health education must be realistically attuned to their needs.

The organization of the health education system should be unified as far as possible, without domination by a central agency, and the links between national, regional and local institutional levels should be appropriate and effective.

The subject matter should be taught as a whole, without a rigid distinction between somatic, mental, social and moral elements. An important function of health education is also to relate one service with another and to portray what is done in such a way as to be able to transcend boundaries and break down barriers where necessary. Generally speaking, problems and solutions in health education are identical for each professional group, but the issues are not always understood in the same way.

People are not accustomed to health education and it is important to help to understand the motives behind the process. Baric[b] has distinguished four models in the organization of health education services:

(a) Dispersed model: there is no service nor are there any agents.

(b) Specialist model: there is a service on all levels manned by specialists.

(c) Coexisting model: there is a formal service, manned by specialists with participation from other professions.

(d) Cooperative model: the health education service functions in the way that is appropriate to its organization and status in society, and all the other professions integrate health education in their everyday activities; joint efforts are planned and carried out simultaneously.

It was thought that the cooperative model is the one to aim at, as it facilitates planning, collaboration, implementation and support in practical terms. Evaluation and change can follow step by step. One important consequence of this process might be that professional experts would become less dominant influences.

In short, health education should be organized to facilitate. The specialists should be skilled at stepping tactfully over boundaries which exist and at causing them to crumble when they become barriers.[c] It is the specialist's task to identify, to promote, to plan, to foster implementation and to support.

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[a] WHO Regional Office for Europe. *Principles and methods of health education.* Report on a Working Group, Dresden, 1977 (in preparation).

[b] Baric, L. *The theory and practice of health education as related to the place of health education in health administration* (unpublished document ICP/HED 003/7)

[c] WHO Regional Office for Europe. *Problems of children of school age I (5-9 years).* Report on a Working Group, Copenhagen, November 1975. Copenhagen, 1976.

3.2 Discussion

In the general discussion which followed the presentation of the paper three main interests were expressed.

(1) Those participants from countries where health education has made only a slight impact, and has little or nothing in the way of an essential structure, wondered about the means of initiating the process.

(2) Networks which enable people to achieve what they want for themselves were regarded as especially important.

(3) The cooperative model is the one which most countries aspire to reach. However, it was agreed that to reach the goal, use of the other three models is unavoidable. In any case it might eventually prove difficult to achieve what is in essence an ideal, without a degree of overlap with the other models.

Participants then made comments from the point of view of their countries on the basis of written notes given to the Rapporteur beforehand. The comments were wide-ranging. At one end of the spectrum, there were participants who could claim no integration of health education services of any significance and were either satisfied with the informal arrangements already being made or curious to discover how to initiate services. At the other end, some were able to describe arrangements which are complete in terms of planning and integration, the system originating from central ministries of health and education and flowing downwards through regional and local authorities to schools, nurseries and primary care services where health education finally has its impact upon children and young people. In between these two extremes, there were those who reported a semblance of the cooperative model, whose application is, however, inhibited in a number of ways, sometimes because of a lack of organization or legal enablement or sometimes because the provisions for co-ordination and implementation are incomplete. Some countries seem forced to rely on the mass distribution of material of various kinds, while others have a structure available but no ultimate means to make use of it because adequate training is generally lacking. Most agreed that the cooperative model should be the aim, although this is far from being attained for the time being.

With regard to the countries where a coordinated system is either in existence or in embryo, it was noted that:

(1) legislation has been enacted or some central body was set up in the late 1960s or early 1970s, and

(2) integration of services is an intricate, complicated and difficult matter.

In an attempt to summarize the comments without going too much into detail, the theory of integration is described in diagramatic form, with an indication of the complexity involved (Fig. 1). It should be noted in particular that services must not only be in touch with each other but also by some means must communicate adequately with parents, families, children and young people. Where countries have set up a central coordinating body independent of central government, they experience further complexities. Participants found the diagram acceptable.

Fig. 2 describes the implications of the integration of health education services in schools, particularly secondary schools. This diagram is not specific to any country but again is intended to show the intricate arrangements which are necessary in theory.

4. Health education of educators

4.1 Presentation

Training educators in health education techniques is closely related to the services provided for the development of children and young people. There are three issues:

(1) Who are the people to be educated, and by what means?

(2) What is the nature of health education for children and young people?

(3) In what way can the health education techniques be imparted, within the framework of professional training, to persons who are in daily contact with the young, such as kindergarten and school teachers, sports trainers, youth club organizers and factory supervisors?

Fig. 1. INTEGRATION OF HEALTH AND EDUCATION SERVICES

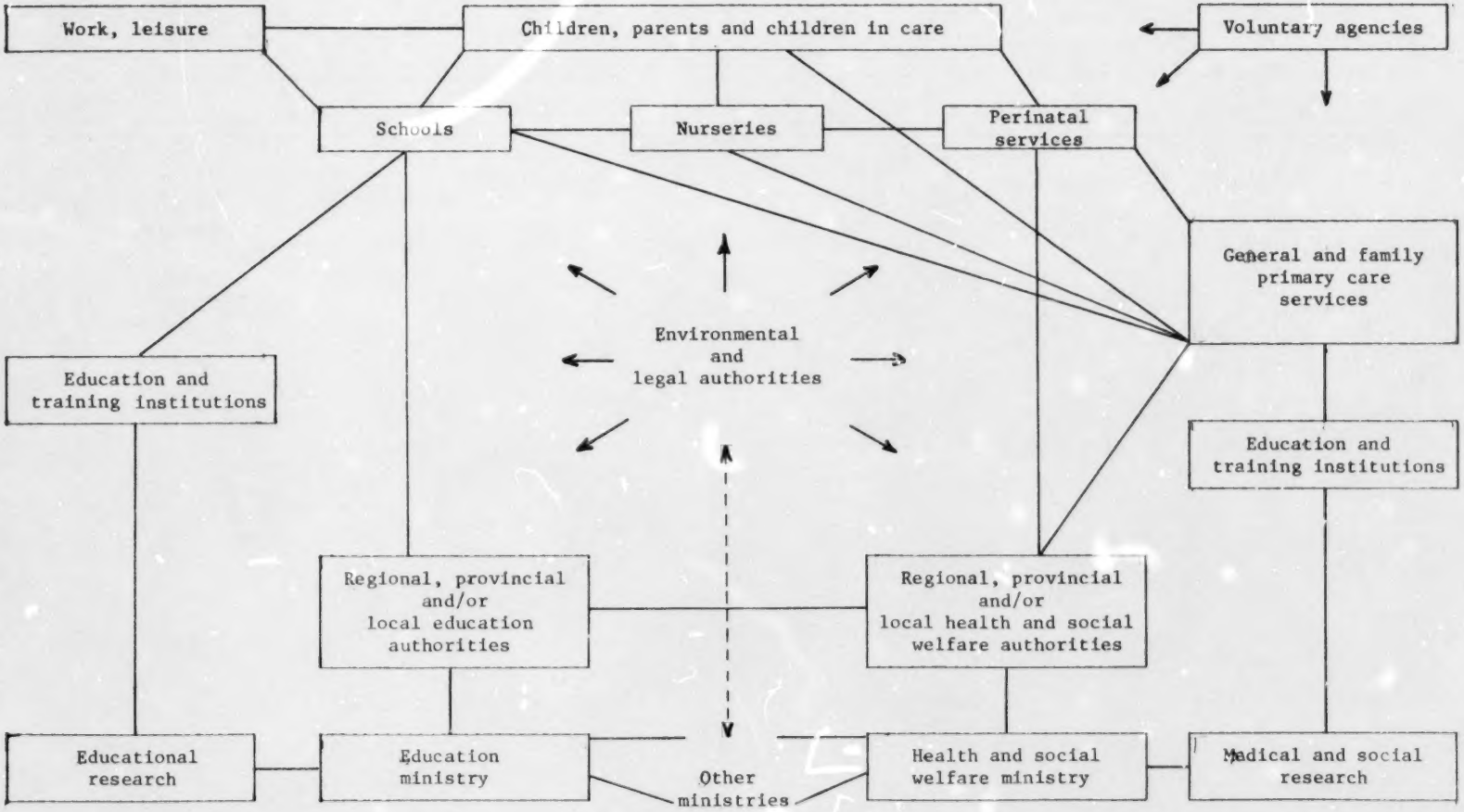
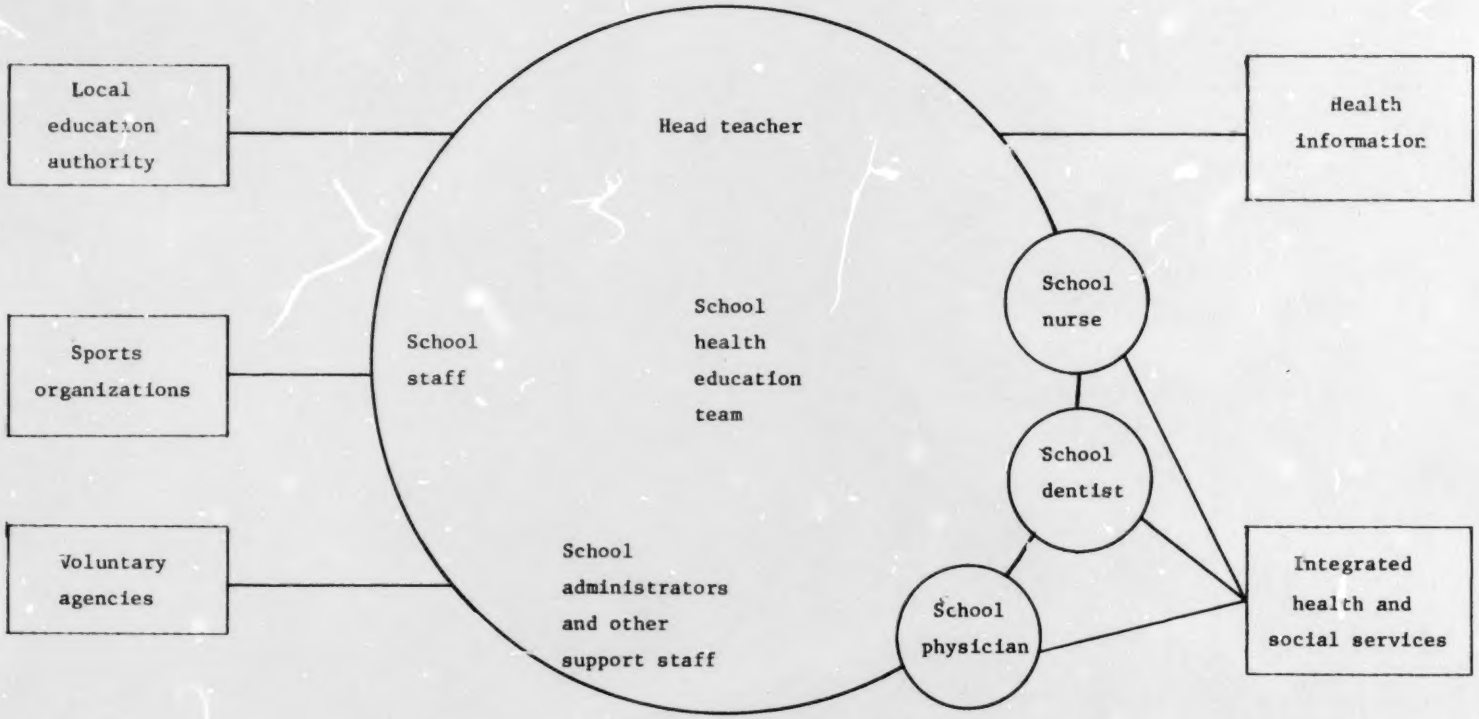


Fig. 2. INTEGRATED HEALTH EDUCATION IN SCHOOLS



The answer to these questions is complex. For instance, those who are not trained in one of the health care professions need knowledge about somatic illnesses. Parents particularly need educating in the various aspects of children's health; for instance, an experiment in Sweden showed a remarkable fall in the incidence of caries once parents had been informed by dentists about the mechanisms underlying the development of this condition. As the child grows older and spends more time outside the family, in nurseries, preschool settings, school and elsewhere, he comes in contact with increasing numbers of health educators. Nursery nurses, school teachers, school nurses, school physicians and dentists all have an impact on the health education of the child, sometimes accidental, sometimes inappropriate and sometimes misleading. How is this situation to be avoided? What kind of training in health education and in methods of teaching children should be given to those being prepared for the health care professions?

Health professionals need to know how to teach, and to practise teaching; parents and teachers need to be made more aware of the health implications of what they do and teach. In addition, differences between professions in philosophy and aim need to be reconciled. As with integration, so it is with the training of educators in health education: the matter is complex.

Health education is not only a means of preventing disease. It is also concerned with the physical education of children. This may be regarded as its main positive function. A controlled routine, a sound regular diet and suitable physical activity are all means whereby this function may be realized.

The formal educational system can be a help to society in solving some health problems, but it should not be relied upon to solve them all by itself. That children be healthy and sound in body and mind is an aim for the whole of society, and schools have a part to play in its attainment. However, some hazards in society, such as traffic accidents and industrial diseases, cannot be eliminated by the formal education system. The school can only do what is appropriate for it. Each society has its values and many of these are transmitted informally rather than by formal means.

4.2 Discussion

In the first stage of the discussion participants attempted to redress what they thought was a certain imbalance in the paper by suggesting that psychological, social and moral issues are as much the concern of a school as somatic ones. Health education can help to change an entire situation, not merely some of it. If there is an imbalance in the values of a society, then education, whether with the aid of preventive medicine and/or that of parents and teachers, could influence policy makers, help to change policy and so redress the balance. A system should be responsive to the needs of children as society sees them and as children themselves see them. Some considered biological knowledge comparatively easy to transfer, while psychological and social knowledge and moral values are extremely difficult to impart. Most believed that health education is concerned with all these issues, whether easy or difficult.

From this point discussion centred on the integrity of the individual rather than the integration of a system. Some asked the question "Are teachers so integrated in terms of personality that they are able to act like psychotherapists where children are concerned?" Most saw this question as exaggerating the issue, but agreed that teachers are intimately concerned with personal matters, and have to deal with sensitive topics like sex, human reproduction, relationships and family life in the course of their work. In these circumstances their own personalities are bound to have an influence on the quality of their teaching and on the nature of their pupil's learning. The idea of "vulnerability" was mentioned in this context; once an individual is aware of his vulnerability, then he has passed through an important stage of adolescence, that of feeling invulnerable; this stage provides essential experience for the attainment of maturity; good teachers are mature people.

Participants recognized that there is a degree of alienation[a] among pupils as far as their schools are concerned, and this affects their perception of health education as does the apparent insecurity of many teachers who have to deal with the subject. Alienation among pupils and lack of confidence among teachers impedes health education within schools. Where pupils are sympathetic towards the general aims of a school, and where teachers feel confident about the subject, communication on both sides is in the nature of things easier and more effective. Innovation, however, is never easy, the process consisting first of negotiation and then of bargaining, agreement, contract and evaluation - on the part of all those concerned.

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[a] Raven, J. *Education, values and society: the objectives of education and the nature and development of competence.* London, H.K. Lewis, 1977.

There followed a period in which participants were encouraged to comment and discuss the working paper from the point of view of their countries. In order to avoid limiting the period allotted to discussion by the subgroups, only participants wishing to contribute directly relevant information on the subject made comments; they were from the German Democratic Republic, the Federal Republic of Germany, Hungary, Poland, and the United Kingdom. All these countries have made progress in the training of health educators. The first three have had considerable experience in the matter, arising from their integrated system for its application, as referred to earlier. The description given by the participants from the Federal Republic of Germany and the United Kingdom showed that developments in their countries are less advanced. Much has been achieved in the Federal Republic of Germany in imparting health education techniques to teachers in schools, in the light of detailed studies concerning health beliefs among children. In the United Kingdom success in the same sphere has stemmed from successful curriculum development in health education. It was felt that no country has made great headway, particularly at the stage of initial training of physicians.

In the same way, evaluation of what has already taken place in the context of professional training has been insignificant. Nevertheless all considered evaluation highly important. A comprehensive survey of approaches to evaluation was given by the participant from Poland.

In the discussions which followed, all agreed that there is a close relationship between satisfactory integration of services and proper provision for training of personnel and parents in the necessary techniques. Knowledge of each other's role was considered to be just as important as health knowledge itself.

5. Discussion in subgroups

At this point, the participants decided to split into three subgroups, each of which would consider the topic of the meeting with reference to certain age ranges: 0-5, 6-16 and 17-25 years, i.e. essentially the preschool period, the period of compulsory schooling and, after leaving school, the period of late adolescence and early family life. The subgroups gave themselves, within these limits, three tasks:

(1) identification of the health education component of all relevant services and professions;

(2) identification of factors promoting and/or hindering the integration of health education in these services and professions; and

(3) investigation of the process whereby integration of the relevant services and professions may be initiated and completed.

The following is a summary of the discussions of each group.

Age range 0-5 years

Among those with a health education function for this group are physicians, nurses, midwives, dentists, child minders, superintendents of clinics, nurseries and kindergartens, and above all parents, together with sibling members of the family, neighbours, friends and relatives.

Inhibiting factors are ignorance and uncertainty among parents, incomplete agreement among professionals, and inadequate appreciation of the psychological needs of the group.

Promoting factors include a high degree of technical efficiency on the part of medical services, adequate procedures as far as immunization and other preventive measures are concerned, and a close interest on the part of all concerned in the welfare of infants and young children.

Age range 6-16 years

Those involved in health education for this group include teachers in schools, psychologists, nurses, physicians, dentists, pharmacists, medical receptionists, social workers, civic leaders, clergy, police, environmental health officers, broadcasters and journalists.

The main inhibiting factors are professional autonomy and isolation, the cost of extra personnel, shortage of specialist staff, lack of concern among the general public and among children, lack of clear knowledge among the professions other than teaching, lack of a broad perspective about health among teachers, and absence of a suitable curriculum.

Promoting factors include shared problems, increased awareness of the central government, general improvement in living standards, existence of a central coordinating or organizing body, feelings of respect, understanding and collaboration between professions where these exist, and the sense of community life in a school.

Age range 17-25 years

The professionals concerned with this group include those who work in secondary schools, trade schools, colleges and universities, the armed services, hospitals, general practitioner, career and family counselling services, youth clubs, sports clubs, special interest groups, parent education groups, the police and probation services.

Inhibiting factors include professional and institutional self-interest and especially the anticipation of loss in financial status, power or autonomy, outdated and irrelevant curricula in school programmes as well as in professional education and training, failure of the health professional to enter into a dialogue with the consumer concerning his real and felt needs, and the assumption by the providers of a service that solutions within their competence are perceived as true solutions by the consumer.

The main promoting factor is the interest of the young people themselves. In response to growing uncertainty due to the rapidly increasing rate of social and economic change which has become a continuing factor in the lives of young people everywhere, they have an intense interest in personal relationships and job prospects; thus provision for counselling on careers and other factors related to adult life should be made in general health education programmes throughout the Region.

6. Conclusions and recommendations

Procedure

The three subgroups reassembled in plenary sessions and reported the results of their discussions. The Group then decided to formulate its conclusions and recommendations separately for each of the three age ranges assigned to the subgroups, as follows.

Age range 0-5 years

1. Educational counselling in pregnancy is infrequently provided. Clearly, both parents can exert a powerful educational influence on their children from the outset; sufficient importance is not always attached to this influence in services and economic arrangements.

2. Self-identification and growth of personality in relation to the social environment are major features of development in infants and children.

3. The integration of health education services requires that different groups work alongside each other. However, as the position of organizations and professions varies from country to country, no universally agreed list of these can be compiled.

4. Since integration of services is complex in terms of organization, planning is essential. The following steps in planning are recommended: by a process of consultation, identification of health-related issues and of educational goals derived from these issues; determination of the health education function of each group, organization and profession in achieving these goals; and, finally, development of a strategy for implementing health education services.

5. The planned integration of health education services must include an exchange of views among members of different professions so that agreement can be reached about the methods to be employed and the functions to be performed, about the dissemination of knowledge of health-related issues and its relevance for health education, and about the appropriate distribution of health education materials.

6. Above all, appropriate education and training as well as support for all those concerned with children, particularly parents, should be carefully planned and integrated.

Age range 6-16 years

1. A number of different services and agencies are concerned with health education of children in this group. Their number and importance increases with the child's age and as the role of the parents dwindles in significance. The health education components of their activities vary within and between countries. They often work in isolation, in an autonomous manner, and sometimes rival each other for dominance.

2. There is a shortage of specialist health education staff with coordinating functions at the central level. There is also uncertainty about the appropriate methodology for teaching health education techniques. Measures of effectiveness and methods of evaluation are in short supply.

3. Health education is not attracting sufficient interest and concern on the part of children, young people, the general public and governments.

4. Those currently involved in the health education of children and young people have usually received inadequate training initially; teachers are ill prepared on health issues, and medical staff in general have few educational skills.

5. As the group of children and young people is not homogeneous, some matters are for instance more important before puberty (e.g. accident prevention, cleanliness, exercise and preparation for puberty) and others during and after puberty (e.g. sex education, preparation for family life, and education about smoking, drugs and alcohol).

6. The potential of each service must be determined, and needs met in terms of support and training. Additional resources may be necessary. The service provided by each agency must be coordinated with other services on a consultative basis. For this purpose an appropriate structure is necessary. Some kind of central coordinating agency would seem to be desirable. Staff dealing with health education should be appropriately trained, and satisfactory methods of evaluation disseminated.

7. Those services which are attractive to young people, like sports clubs, youth clubs and other more informal groupings, should be linked more closely with formal education and health services. The methods and content of health education should be worked out together with the young people, according to the requirements at various ages. The multidisciplinary nature of the task must be indicated in curricula for training health educators.

Age range 17-25 years

1. Personal relationships, job prospects and choice of career are matters which are of particular concern to young people in this group and for which counselling may be especially necessary; the most important aspects of health education for this group are those which contribute to an increase in personal responsibility.

2. The real and felt needs of this group should be systematically researched; curricula in schools and higher or vocational education establishments should be examined to determine their relevance to the needs of those they purport to serve. Informal influences which shape the behaviour of members of this group should also be identified.

3. All the above factors should be taken into consideration with a view to making appropriate changes based on consultations with all those concerned.

General conclusion

It was felt with reference to all three age ranges that governments, through legislation, can play a decisive part in either promoting or limiting the integration of health education services for children and young people.

ANNEX

LIST OF PARTICIPANTS

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[a] Participation expenses not paid by WHO.

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